



## SAN RAMON VALLEY UNIFIED SCHOOL DISTRICT

### ADULT CHAPERONE VOLUNTEER PARTICIPATION IN VOLUNTARY ACTIVITY HOLD HARMLESS AND MEDICAL TREATMENT AUTHORIZATION

*(For all Chaperone Volunteers who are not employed by the  
San Ramon Valley Unified School District.)*

Date \_\_\_\_\_

Name \_\_\_\_\_

Activity \_\_\_\_\_

Date(s) of activity \_\_\_\_\_

I have agreed to be a volunteer chaperone for the above mentioned activity.

- The school reserves the right to revoke volunteer privileges at any time.
- School trip drivers must have an approved "Personal Automobile Use Permission Form"
- I represent that I have not been convicted of a felony, and that I am not a registered sex offender as defined by Megan's Law, California Penal Code Section 290.

I understand that this activity could cause illness and/or injury. In the event of illness or injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care considered necessary in the best judgment of the attending physician, surgeon or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

As a condition of my participation as a San Ramon Valley Unified School District (District) chaperone volunteer in this activity, I acknowledge that workers' compensation is my only recourse for any bodily injuries sustained during my course as a District volunteer. I agree to waive all claims against San Ramon Valley School District and to indemnify and hold District, its officers, agents, and employees harmless from any and all liability or claims, demands, losses, causes of action, suits or judgments of any kind whatsoever that I, my heirs, executors, administrators or assignees may have against the District or that any other person or entity may have against the District because of any death, bodily injury, personal injury, or illness, or because of any loss to property that may arise out of or in any way be connected with the above described activity. This waiver shall not apply to any occurrences that may arise solely out of the negligence of the District, its employees or agents.

Signature \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_ Policy no. \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Phone Work: \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_

For Office Use Only:  Copy of picture ID attached  Received by: \_\_\_\_\_

Date: \_\_\_\_\_